Items 12a, 12b, 18a, 18b, etc. "Etiology"

Q: ICD-9-CM does not have codes for all of the conditions of our clients. For example, Angleman's syndrome, or Happy Puppet syndrome, does not seem to exist in ICD-9-CM. If there is no code for a given condition, what should we do?

A: Many new syndromes are being documented for which there are no current ICD-9-CM codes. Our Office is maintaining a record of these conditions and, in conjunction with the national ICD-9-CM registry, will be assigning expanded codes for those syndromes DDS and ARCA professionals wish specifically to report.

The assigned coding for Happy Puppet syndrome is 758.8

Items 19, 23, 27b, 28b, 29b, 60, 62 Items Using "9" As Undetermined

Q: Are there any time limits on leaving a client coded as "9" (suspected, not diagnosed)? In the past, there was a six month time limit on items that had this code; is that still in effect?

A: Yes, there is still a time limit on the use of "9" codes of this kind. For items 19, 23, 27b, 28b, 29b, 60 and 62 ONLY, the "undetermined" or "suspected" situation should be resolved within NINE MONTHS. This means that the "9" codes should be changed to "real" codes within nine months of the CDER entry.

Item 25 Date of Determination

Q: If a client has been coded as a "9, suspected, not diagnosed" in item 23 (Autism), what do we put as the "Date of Determination" in item 25? The computer will not allow us to enter 0000 or to leave the item blank.

A: You will need to enter some kind of a date. If the client is coded as a "9," he/she has been, or is in the process of being, referred for additional testing to determine whether autism exists. The date at which that decision for referral was made, or the date of the referral itself, could be used in item 25. The actual date that is selected will depend upon the particular intake and assessment processes that have been established by the regional center or developmental center.

tem 33a Other Type of Developmenta Disability

Q: On Manual page VI.9.1, dated October 1986 and included in the October 1986 Update Bulletin, you state "Treatment is defined as care and management." This definition is unfamiliar to me. I question the fact that it is accurate and feel that it could be misleading.

A: This definition of "treatment" was obtained from Dorland's Illustrated Medical Dictionary, 26th Edition, 1981, which defines treatment as "The management and care of a patient for the purpose of combating disease or disorder."

Q: How do we code a client who has borderline intelligence but whose adaptive behavior is very low because he/she has been "institutionalized" for so many years that he/she has become dependent upon the services and assistance provided by the regional center system?

A: We understand this question to mean a client whose Level of Retardation (item 11) averages out to "borderline" when both numerical IQ and Adaptive Behavior ratings are taken into account. Generally, such persons would not be eligible for regional center services. However, in the specific instance of those few persons who have been treated as mentally retarded most or all of their lives, thereby having become dependent upon the system and having little or no ability to develop beyond this level of dependence, one could use the ICD-9-CM category of 309.9, "Unspecified Adjustment Reaction." It is anticipated that this code would be used rarely.

Q: [In reference to previous Q and A.] If this is the category under which DDS wishes these people to be coded, I shall, of course, comply. I do, however, have some reservations [about your suggestion that the ICD-9-CM code of 309.9 be used]: My primary concern is that the information that we are feeding into the CDER is inaccurate as well as misleading. An adjustment reaction implies a maladaptive reaction to a specific identifiable psychosocial stressor, not a life-long pattern of maladaptation, and it also implies recovery within some reasonable period of time whereas a developmental disability is a handicapping condition that continues or can be expected to continue indefinitely.

They say that complaining about a problem without suggesting a solution to the problem is not good. My suggestion for a solution is to get a clear definition as to who exactly is meant to be included for eligibility under the "fifth category." Good Luck!

A: In the above case one could consider the client to have mild mental retardation based on the AAMD definition which combines IQ score and

Item 33a Other Type of Developmental Disability (cont.

adaptive functioning together to determine overall level of retardation. If this were not acceptable to the physician or ID team the category of "Other Developmental Disability" may be used, provided the client has a substantial handicap and requires treatment similar to that of the mentally retarded. The etiology of this disability could then be coded as 309.9, Unspecified Adjustment Reaction. Office staff utilizing CDER data would be cognizant of the fact that this category is being utilized for those persons having lasting adjustment reactions to long periods of hospitalization. Such information would not, therefore, be "misleading."

Q: Are "atrophy of the optic nerve" and "expressive dysphasia" conditions which would qualify for item 33a, Other Type of Developmental Disability?

A: No, at least not by themselves. Such conditions could have various causes. Without more information, it is impossible to make a true determination but, generally, such conditions would <u>not</u> qualify for inclusion as Other Type of Developmental Disability.

Item 47 Risk Factor

Q: How do you code item 47, "Other" risk factors, when you don't know if there were other conditions? Do you use a "9" for "unknown" or a "2" for "no"?

A: You would handle it just as you handle the other items in the section. If you are reasonably sure that there were no additional factors, beyond those mentioned in Risk Factor items 35-46, then code item 47 as "2" for no. If you are not sure whether there were additional factors, use code "9" for unknown.

Items 50a - 53a Menta Disorders

Q: When we tried to enter two DSM III codes in Axis I but only one DSM III code in Axis II, the computer would not let us go on to the next item; the computer required a second entry under Axis II. If the client doesn't have a second Axix II condition, what do we do?

A: Enter V71.09, "no diagnosis or condition on Axix I/II." The computer is set up to require a second entry under each Axis if there is a first diagnosis under that Axis.

Q: When we tried to enter the DSM III code of 299.90, Childhood Onset Pervasive Developmental Disorder, Full Syndrome, in Axis I of item 50a, the computer would not allow the entry. Why not? Isn't this a "legal" mental disorder condition for our clients?

A: The computer programs have now been modified so that you can add the DSM III codes of 299.90 or 299.91, plus the codes 299.80 or 299.81. However, if these codes are used, it must be apparent from the client's record that he/she meets all of the diagnostic criteria indicated in the DSM III Manual. Care also should be taken to differentiate these conditions from Autism, which is to be coded elsewhere on the CDER form, not in the Mental Disorders section. Of most importance, these conditions should not be considered as the sole conditions that make the client eligible. A developmental disability diagnosis also must be present and entered in the appropriate section of the CDER form.

Items 54a - 59a Chronic Medical Conditions

Q: Even if you enter codes for "none" or "unknown" for Hepatitis, the computer still expects you to enter an "Impact" code in item 54b (- 59b). Is this right?

A: First, to enter "unknown" for Hepatitis B, you would enter 070.34 (Hepatitis B immune status unknown). Second, as you must enter Hepatitis status for all clients, you also always must enter an "Impact" code. For the "unknown" Hepatitis immune status in item 54a, say, the Condition Impact Code in item 54b would be "0," no evidence of impairment.

Item 60 or 62 Leve of Hearing (or Vision) Loss Uncorrected

Q: Shouldn't there be a category for "unknown hearing/vision loss," for those clients who are not responsive enough to allow a determination of level of loss?

A: Use level "9," "hearing (vision) loss suspected, severity undetermined."

Item 61 or 63 Level of Hearing (or Vision) Loss Corrected

Q: How do you code it if the level of correction is different for the two ears (eyes)?

A: Rate the hearing (vision) at what is judged to be his/her overall level of corrected hearing (vision), "averaging" the correction for the two ears (eyes), if necessary.

Items 64 - 69 Behavior Modifying Drugs

Q: Do you code Type of Medication in items 64 - 69 when the client is no longer taking medication?

A: No. If the client is no longer taking a given medication, as will be indicated in item 70 through the use of codes "2" through "5", then the items for Type of Medication, items 64 through 69, should be coded "2" for "no."

Q: Should we code item 65 as yes if the client is receiving an anti-depressant medication for bedwetting?

A: No. Bedwetting is not usually considered to be a "maladaptive behavior" problem. The instructions for items 64 - 69, Type of Prescribed Medication for Maladaptive Behavior, indicate that if a person is receiving one of the medications for reasons other than maladaptive behavior then the medication should NOT be listed as a "yes."

Item 70 History of Prescribed Medication for Maladaptive Behavior

Q: There is some confusion as to what "levels" 5 and 6 of this item mean. Level "5" could mean client was on medication in the past, but hasn't been on it for four years. If level "6" means no documentation of ever having taken such medication, what do you do with the interim period -- i.e., client has been off the medication for more than four years but there is documentation that the medication was taken in the past. Persons on the Abnormal Involuntary Movements (AIMs) project want to restrict the use of level "6" to persons having no known record of ever having been on such medication.

A: Use level "6" as the AIMs project recommends, for no documented evidence of ever having taken the medication. Use level "5" for persons who once took the medication but who have not taken the medication for four or more years. Thus, the definitions should read:

5 Has not received medication(s) during past four or more years, but did take the medication(s) in the past.

6 No known documented history of ever receiving medication(s

tem 72 Dystonia (Abnorma Involuntary Movement)

Q: The definition of dystonia should be expanded.

A: Please add the following to the definition of dystonia given in the CDER Manual on page VI.16.2:

> Dystonia includes persistent deviations due to abnormal postures such as contractures.

This definition is especially pertinent for physicians of non-ambulatory clients. (Source: Sonoma Neuropharmacology Assessment Project [AIMS Project])

Items 76 - 85 Special Health Care Requirements

Q: On Manual page VI.17.5 "Special Diet" is listed. The definition for this item is judged to be unclear. Can anything other than regular consistency food and a standard calorie diet be considered as a "Special Diet"?

A: Special Diet should be coded if the client's diet requires special preparation time or extra supervision. Any modified consistency diet should be included, as should diets designed for special dietary problems such as are listed in the Manual. Low or reduced calorie diets usually would not be considered as "special diets" unless they are required because of specific clinical condition such as clinical obesity or Prader-Willi syndrome.

Q: Shunts are not listed among special health care requirements, where should they be coded?

A: As shunts usually do not require on-going special nursing attention, they were not included in this section and should not be coded.

Item 99 Specia Legal Conditions, Conservatee Under Probate Court

Q: Is a client currently a conservatee under the Probate Court if Letters of Guardianship were issued in the past? Since Letters of Guardianship are no longer issued for adults, are these still valid and how do we answer item 99?

A: For adult clients, if Letters of Guardianship were issued in the past, then item 99 should be answered affirmatively, unless there is evidence that the guardianship has been terminated through a court proceeding. The Probate Code section 1485 established that persons under guardianship as of the date of the law change were to be deemed to be under a conservatorship. This "deeming" of guardianships to conservatorships occurred automatically, without the need to petition or in other ways contact the court. Again, the only case in which this does not occur is when the guardianship was legally terminated.

For minor clients, guardianships terminate upon attainment of age of majority. There is no automatic conservatorship given in these cases. If a conservatorship is considered necessary, a new petition for conservatorship must be filed with the court. Contact DDS' Legal Office for an information packet.

Items Evaluation: 15, 60, 66 Toileting, Receptive Nonverbal Communication, Clarity of Speech

Q: In the October Update Bulletin you gave us a CDER Answer Sheet on which all of the possible codes for each item were indicated. There are three mistakes on that sheet: item 15, item 60, and item 66 have incorrect numerical codes.

A: You are right. The correct codes for these three items are:

15. Toileting Y, N, 1-5
60. Receptive nonverbal communication N, 1-4
66. Clarity of speech 1-5

General Questions

Q: Your October 1986 Update Bulletin, on the goldenrod page numbered VI.25.1 - VI.25.4, refers to form DS 3573. What is that? The CDER form is DS 3752 and the Answer Sheet is DS 3752.

A: It is a typo. We were referring to the CDER form (packet) itself, DS 3753. Sorry.